



CLAIM FOR REIMBURSEMENT for Sponsoring Organizations of Day Care Centers

READ INSTRUCTIONS carefully BEFORE completing claim. **SEND ORIGINAL ONLY.**

1. CACFP Sponsor #	2. Month/Year Claimed: Month Year	3. Adjusted Claim <input type="checkbox"/> Yes
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[illegible]

12. CERTIFICATION by AUTHORIZED REPRESENTATIVE (a completed Certificate of Authority must be on file)

I certify, to the best of my knowledge and belief, that this claim is true and correct in all respects; that records are available to support this claim; that it is in accordance with the terms and conditions of existing agreements; and that payment therefore has not been received. I recognize that I will be fully responsible for any excess amount that may result from erroneous or neglectful reporting herein. Also, I am aware that deliberate misrepresentation or withholding of information may result in prosecution under applicable state and federal statutes. I agree to contact CACFP if there are any changes in the approved application and sponsor agreement.

Signature _____

Date _____

Title _____

13. THIS FORM PREPARED BY

Name _____

Telephone (include Area Code) _____

Title _____

FOR STATE USE ONLY

Comments:

PROCESSED

Date	Initials
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RETURNED

Date	Initials
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REJECTED

Date	Initials
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Reason: ☐ Incomplete☐ Other

GENERAL INSTRUCTIONS

- A. Claim for Reimbursement for Sponsoring Organizations of Day Care Centers (DOH-3703) must be TYPEWRITTEN or HANDWRITTEN legibly in BLACK or BLUE INK.
- B. A claim is for one month only. Report program information for one calendar month only on each claim form.
- C. All Centers Sponsoring Organizations must submit a DOH-3703. If your Sponsoring Organization collects the same information required by the DOH-3703 on an agency form or on a computer spreadsheet, you may request approval to use an alternate form. Use as many claim forms as needed.
- D. SIGN the claim before submitting it to CACFP to avoid a delay in payment. Only the original signature of an authorized representative, as indicated on the Certificate of Authority (DOH-3671), will be accepted.
- E. Submit claims by the 10th of the month following the claim month. Claims must be received within 60 days of the last day of the claim month to be eligible for payment.
- F. At-Risk Snacks and At-Risk Suppers for eligible centers and meals claimed for Shelters are paid at the free rate. The amount of reimbursement for all other meals and snacks will be calculated on a claiming percentage method, based on the number of free, reduced and paid participants as reported on this claim.
- G. All receipts, invoices and other evidence of purchase must be kept and available for reviews for a period of 3 years after the submission of the final claim for the fiscal year for which they pertain.
- H. No further monies or other benefits may be paid out under this Program unless this report is completed and filed as required by existing regulation (7 CFR 226).
- I. Your claim WILL BE RETURNED or delayed if not complete.

SPECIFIC INSTRUCTIONS

The numbers below correspond with the numbered boxes on the Claim for Reimbursement for Sponsoring Organizations of Day Care Centers (DOH-3703).

1. CACFP Sponsor #: Write in your 4 digit CACFP sponsor number, as stated on your CACFP approval letter.
2. Month/Year Claimed: Enter, in numbers, the month and year that this claim or adjusted claim covers.
3. Adjusted Claim: Check if this claim is an ADJUSTED CLAIM. An adjusted claim must include only changes from the original claim; i.e. additional meals you are claiming or a negative amount for meals you have over-claimed. Do not include meals previously claimed.
4. Sponsor Name: Enter the complete name and address of your Sponsoring Organization as stated on your CACFP approval letter. If the address has changed, send a letter with the new information. The letter can be sent with the claim.
5. CACFP Center Number: Enter the four-digit number assigned to each center.
6. Name of Center: Write in the name of the center on the line next to the corresponding CACFP center number.
7. Total Days of Operation: Enter the number of days each center was in operation during the month of the claim.
8. At-Risk ADA: For any center that claims At-Risk Snacks and/or At-Risk Suppers, the ADA for children eligible for the At-Risk Snacks and/or At-Risk Suppers must be reported. ADA is determined by adding daily attendance for a month and dividing that total by the number of days of operation for the month.
- 9a. ADA for all non-At-Risk meals: For any center claiming traditional CACFP meals/snacks, write in the ADA for non-At-Risk meals/snacks. If the center has both At-Risk meals and traditional meals, some/all of the attendees may be reported in both #8 and #9a. For example, if a center was approved to serve At-Risk Snacks and lunch, a child receiving both meals would be reported in the ADA of both columns #8 and #9a.
- 9b.c.d. Child Care, Head Start, O/S School Hours, Adult and Shelter Enrollment Eligibility: Write in the number of participants that are enrolled in each of the following categories: free, reduced, and paid for each center. Enrollment numbers must reflect current enrollment for the claim month. Do not enter enrollment eligibility data for At-Risk centers reporting At-Risk Snacks and/or At-Risk Suppers only.
- 9e. Total Enrollment Eligibility: Report the total enrollment for each center. This should equal the total of 9 b, c and d.
10. For-Profit Eligible Children: Only Sponsoring Organizations of for-profit day care centers approved as Title XX sponsors need to complete this column. Write in the total number of children whose tuition is subsidized by the Office of Children and Family Services or the Human Resource Administration. In order to claim reimbursement, for profit centers must have received subsidized tuition payments for at least 25% of the enrollment or licensed capacity, whichever is less, for that calendar month.
11. Total Number of Meals Served at Center(s): Enter the total number of meals (Breakfast, Lunch, Supper, Snacks, At-Risk Snacks and At-Risk Suppers) served to eligible participants at each center. For centers approved to claim Seconds, enter the number of second meals served in the space provided.
12. SIGN the claim before submitting it to CACFP. Only the original signature of an authorized representative, as indicated on the Certificate of Authority (DOH-3671), will be accepted.
13. Write in the name, phone number and title of the person to contact should there be a question about this claim.

Page Total: Enter the total of each column in the non-shaded boxes.

Grand Total: Combine all page totals and enter as Grand Total on the last page of the DOH-3703.

If you have any questions while completing the claim, call CACFP at 1-800-942-3858 for assistance.

Make a copy for your records and mail the original form to: CACFP, NYS Dept of Health, Riverview Center, 150 Broadway FL 6 West, Albany, NY 12204-2719